NOAA DIVING PROGRAM

DIVE ACCIDENT MANAGEMENT
FIELD REFERENCE GUIDE
FOR
NOAA DMT'S

NOAA Diving Center
7600 Sandpoint Way NE
Seattle, WA 98115

TABLE OF CONTENTS

MEDICAL TREATMENT FOR A CONSCIOUS DIVER

PROCEDURE	TREATMENT NOTES
X ABC's	
X Administer 100% oxygen	
$ Remove exposure suit, dry, and keep warm	
X Place in position of comfort	
X Give one (1) aspirin (325 mg) orally	
X Take vital signs every 5-mins if unstable and every 15-mins if stable - Pulse/per min - Blood pressure - Respirations/per min	
X Gather dive history *(p4)* info from diver/buddy	
X Perform neurological exam *(p 5-7)*	
X Contact medical assistance or EMS *(p11)*	
$ Administer 0.5 liters of water orally per hr x 2 hrs, then reduce to 100-200 ml per hr thereafter	
X If unable to drink sufficient quantities of fluids orally, start IV with Lactated Ringers or Normal Saline – Administer 0.5 liters per hr x 2 hrs, then reduce to 100-200 ml per hour thereafter	
$ If unable to urinate 30 cc's/hour voluntarily, insert Foley catheter and monitor urine output quantity and appearance	

MEDICAL TREATMENT FOR AN UNCONSCIOUS DIVER

PROCEDURE	TREATMENT NOTES
X ABC's	
X Administer 100% oxygen	
$ Remove exposure suit, dry, and keep warm	
X Lateral recumbent position	
X Take vital signs every 5-mins if unstable and every 15-mins if stable - Pulse/per min - Blood pressure - Respirations/per min	
X Gather dive history info from dive buddy and/or eye witnesses *(p4)*	
Perform neurological exam *(p5-7)* & Glascow Coma Scale *(p9)*	
X Contact medical assistance or EMS *(p11)*	
X Start IV with Lactated Ringers or Normal Saline - Administer 0.5 liters per hr x 2 hrs, then reduce to 100-200 ml per hour thereafter	
$ Insert Foley catheter and monitor urine output quantity and appearance	

NOAA DIVER CONTACT INFORMATION

Name of Diver: _____ DOB: _____

Present Address: _____ Zip: _____

Height: _____ Weight: _____ Age: _____ M ____ F ____

Home Phone: _____ Work: _____ Cell: _____

Present Employer: _____

Significant Medical History / Allergies: _____

_____

Preferred contacts in event of an emergency:

Name:_____ Phone: _____

Name:_____ Phone: _____

DIVE HISTORY

Date: _____ Time of Day: _____ Depth: _____ Bottom Time: _____

Breathing Gas: _____ Equipment Used: _____

Did anything unusual occur prior to or during dive? If so, describe

_____

If repetitive, list specifics of previous dives in past *24* hours:

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Location at time of injury: _____Time of onset: _____

Was symptom noticed before, during, or after the dive? _____

If during, was it while descending, on the bottom, or ascending? _____

Has symptom increased or decreased since first noticed? _____

Diver's description of symptoms (include location, type, quality, etc.)

_____

ADDITIONAL DIVE HISTORY

Does pain radiate? If so, where from _____ to _____

Does pain increase with movement or palpation? _____

Have any other symptoms occurred since the first one was noticed? If so, describe _____

Has patient ever had a similar symptom? If so, describe _____

_____

Has patient ever had DCS or AGE before? If so, note when and describe:

_____

Dive Buddy's comments: _____

_____

ADDITIONAL BACKGROUND INFORMATION

Does the patient smoke? ____ yes or ____ no

Has there been any recent exposure to altitude? ____ yes or ____ no

Are there any dive-related problems that could explain the present symptoms? _____

Current medication list: _____

List all medications taken during the previous 24-hours _____

_____

If the diver is female, when was her last menstrual cycle?_____

When did the diver last eat and drink? _____

Describe the activities performed during the dive: _____

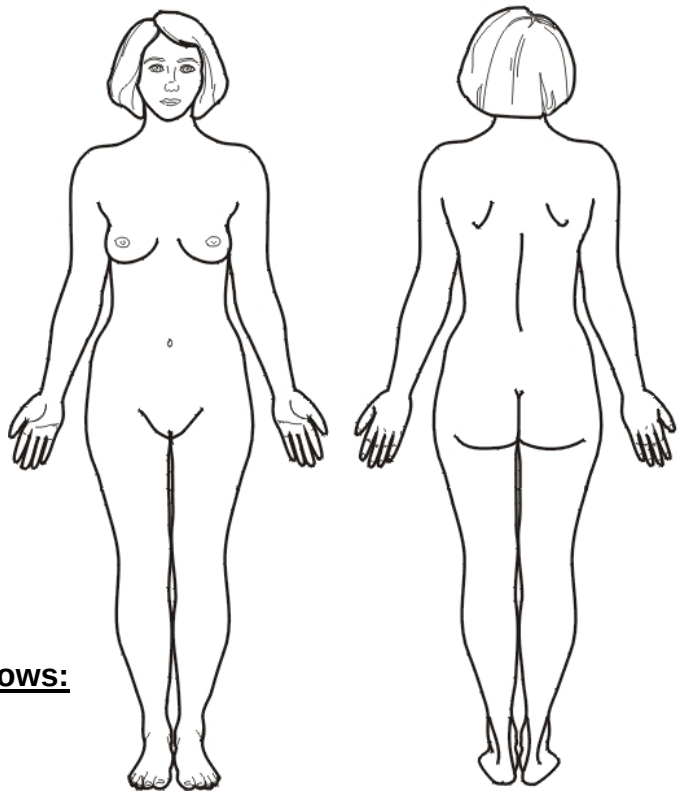
_____

Describe the activities performed following the dive:_____

NEUROLOGICAL EXAMINATION

MENTAL STATUS/LOC	**STRENGTH**	Left	Right
$ Alert to person, place and time	$ Upper Body		
$ Add a nickel, dime & quarter	- Deltoids		
$ Count back from 100 by 7's	- Latissimus		
$ Glasgow Coma Scale (p. 9)	- Biceps		
	- Triceps		
VITAL SIGNS	- Forearms		
$ Pulse/min	- Hands		
$ Blood pressure	$ Lower Body		
$ Respiration/min	- Hips		
$ Temperature	X Flexion		
	X Extension		
COORDINATION	X Abduction		
• Walk	X Adduction		
• Heel-to-Toe	- Knees		
• Romberg	X Flexion		
• Finger-to-Nose	X Extension		
• Heel-Shin Slide	- Ankles		
• Rapid Movement	X Flexion		
	X Extension		
CRANIAL NERVES			
$ Vision/Visual Fields (II)	**REFLEXES**		
$ Eye movements/pupils (III, IV, VI)	*Normal*, *Hypoactive*, *Hyperactive*, *or Absent*		
$ Facial sensation/chewing (V)	$ Biceps		
$ Facial expression muscles (VI)	$ Triceps		
$ Hearing (VII)	$ Knees		
$ Upper mouth/throat sensation (IX)	$ Ankles		
$ Gag & voice (X)	$ Toes (Babinski)		
$ Shoulder shrug (XI)			
$ Tongue (XII)			
SKIN SENSATION (indicate results			
on next page)			
Exam performed by:			
Date:	Time		

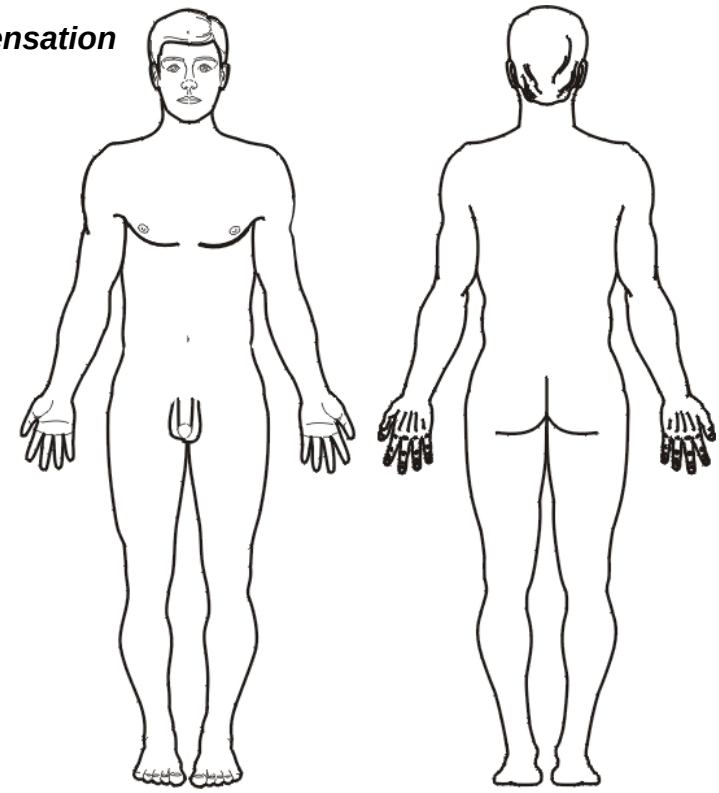
SENSORY EXAMINATION FOR SKIN SENSATION



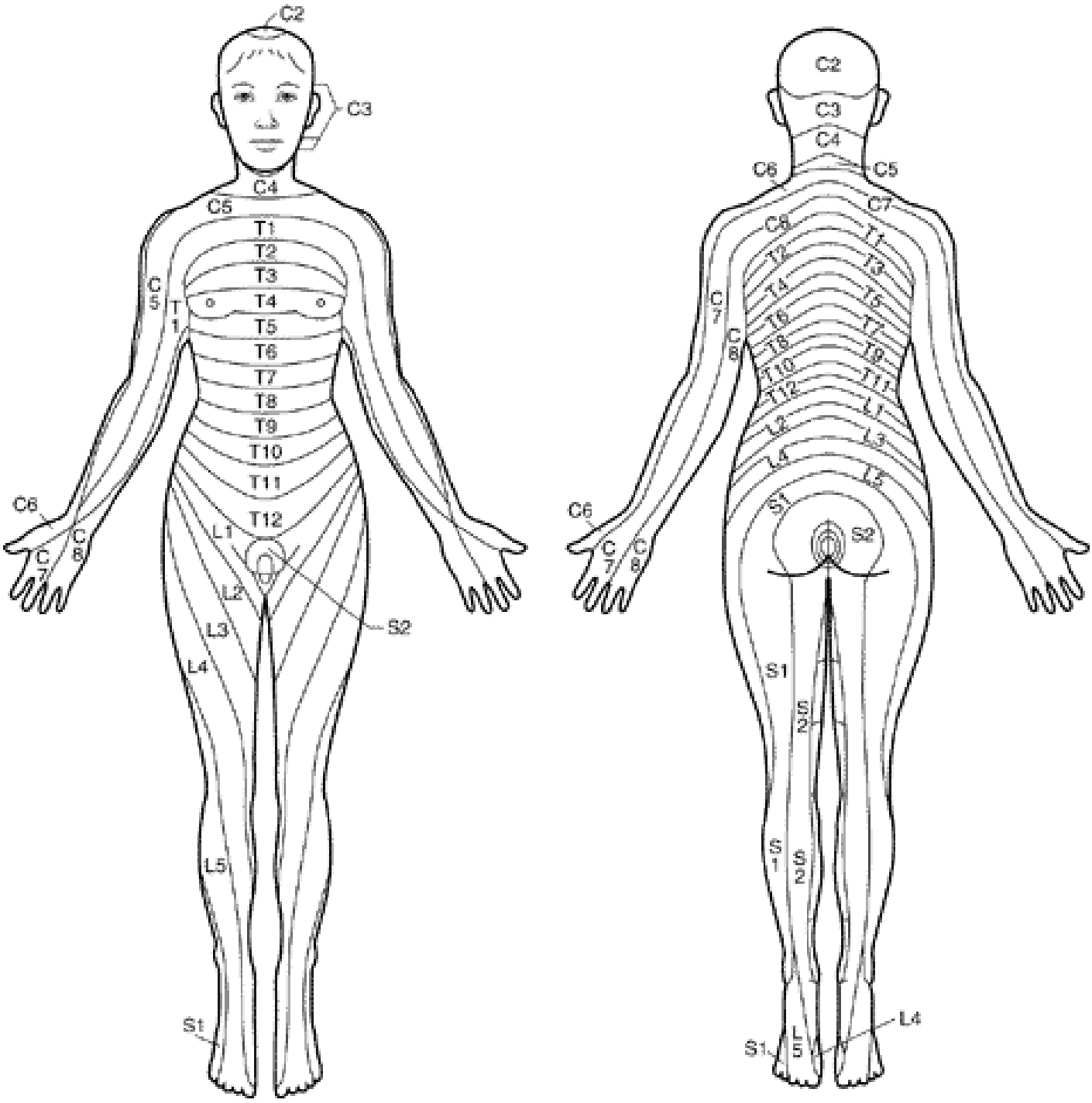
Indicate results as follows:

Painful Area

Decreased Sensation



DERMATOMES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C7
C8
S1
S2
S1
S2
L4
L5
S1

TREATMENT NOTES

GLASGOW COMA SCALE

I. Motor Response
- 6 - Obeys commands fully
- 5 - Localizes to noxious stimuli
- 4 - Withdraws from noxious stimuli
- 3 - Abnormal flexion, i.e. decorticate posturing
- 2 - Extensor response, i.e. decerebrate posturing
- 1 - No response

II. Verbal Response
- 5 - Alert and Oriented
- 4 - Confused, yet coherent, speech
- 3 - Inappropriate words, and garbled phrases consisting of words
- 2 - Incomprehensible sounds
- 1 - No sounds

III. Eye Opening
- 4 - Spontaneous eye opening
- 3 - Eyes open to speech
- 2 - Eyes open to pain
- 1 - No eye opening

Glasgow Coma Scale = I + II + III. A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 is a moderate injury, and 8 or less a severe brain injury.

EMERGENCY CALL-IN SCRIPT

"I am a NOAA Diver Medic and I am calling to report a diving-related emergency requiring immediate medical assistance. The victim is a _____ (age) year old _____ (gender) who is _____ (conscious/unconscious), with the following symptoms after diving with compressed gas…… (describe pain, dizziness, etc.)"

"We have placed the victim in the supine position, and have initiated basic first aid. We have also completed a field neurological exam, with the following results……. (note any deficits). The victim is on 100% oxygen by mask, and we have rendered the following additional treatment……. (CPR, IV fluids, medications, etc.) Last vital signs are as follows….."

Temp: ____ Pulse: ____ Resp: ____ B/P: ____/____

" We are at the following location……(location of diver / landmarks) and request immediate medical transport to……. (receiving facility of choice) via (air / ground) transport"

Note: Do not terminate call….the receiving unit will end the call.

CONTACT INFORMATION

MEDICAL

Local EMS …… ……(911)
USCG …… VHF Channel 16
CAPT Michael Vitch, DMO ..…… (301) 713-3440 (ext. 186) (work)

MOC-P Medical Officer on call…… (206) 409-8725 (cell)
MOC-A Medical Officer on call…… (757) 615-6619 (cell)
Diver's Alert Network (DAN)…… (919) 684-8111

ADMINISTRATIVE CONTACTS

Dave Dinsmore, Director, NOAA Diving Program …..(206) 526-6705 (work)

Steve Urick, NMAO Fleet Diving Officer……..... ..(206) 526-6223 (work)

CHAMBER LOCATIONS & QUALIFIED PHYSICIANS (Seattle, WA)

Primary: Virginia-Mason Medical Center
1202 Terry Ave, Seattle, WA
Hyperbarics Department: (206) 583-6543
24-hour emergency line: (206) 583-6433

Secondary: Diver's Institute of Technology
4315 11th Ave. NW, Seattle, WA
Chamber phone: (206) 783-5542

Tertiary: St. Joseph's Medical Center – Tacoma
Hyperbaric Medical Service: (253) 426-6630
24-hour emergency line: (253) 426-6630

Additional Assistance: Divers Alert Network
Duke University Medical Center, Durham, NC
24-hour emergency line: (919) 684-8111

CONTACT INFORMATION CON'T.

OTHER TRANSPORTATION CONTACTS

U.S. Coast Guard – Boat or Helicopter
(206) 220-7001 or (800) 982-8813
VHF Ch-16 or SFD dispatch

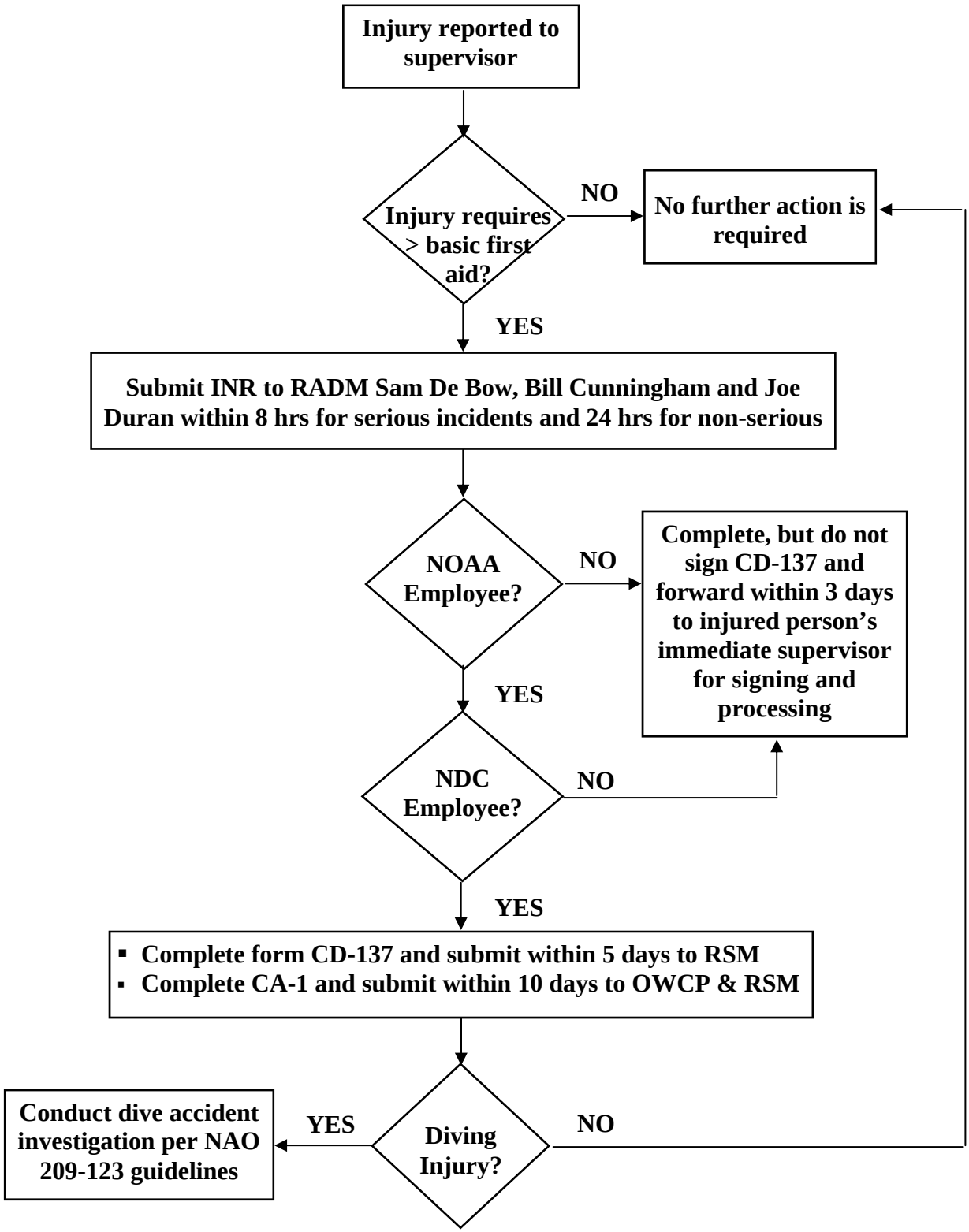
SPD Harbor Patrol
(206) 684-4071
VHF Ch-16 or SFD dispatch

King County Marine Unit
911 or (206) 296-3311
VHF Ch-16 or SFD dispatch

Mercer Island Police / Fire
Rescue (206) 236-3600
VHF Ch-16 or SFD dispatch

Airlift Northwest
(206) 329-2569

NOAA DIVING CENTER
ACCIDENT MANAGEMENT & REPORTING PROCEDURES



Revised: February 2004

TO: LO Management,
CC: NOAA Safety Director, RSM

Complete **the form then email to appropriate parties.** Forward completed form within 24 hours of a job related injury, illness or near-miss. **Note:** Save to your Desktop**.**

Immediate Notification Report	
Supervisor Completing Form	
Job Title	
Last/First/Middle Name	
Facility	
Telephone Number	
Injured Employee or Affected Property Information	
Work Location	
Job Title	
Last/First/Middle Name	
Telephone Number	
Property Identification	
Date/Time of Accident Occurrence	
Location of Accident	
Accident Type (injury/death/equipment)	
Description of Mishap	
Facility Corrective/Preventative Actions Implemented in Response to Accident	
Preventative Action Recommendations	
Additional Comments	
Date/Time Form Completed/Submitted	

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)			2. Social Security Number
3. Date of birth Mo. Day Yr.	4. Sex ☐ Male ☐ Female	5. Home telephone	6. Grade as of date of injury Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)			8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time ☐ a.m. ☐ p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code	
b. Type code	c. Source code
OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness		Date signed
Address	City	State	ZIP Code

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

32. Name and address of physician first providing medical care (Include city, state, ZIP code)

33. First date medical care received Mo. Day Yr.

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
☐ First Aid Injury

Form CA-1,

Rev. Apr. 1999

FORM CD-137
(Rev. 5/89) LF
DAO 209-4

U.S. DEPARTMENT OF COMMERCE

Report of Accident/Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

Case: _____ Control: _____
Date Received: _____
Type/Source: _____ / _____
Org. Code: _____

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report: ☐ Accident ☐ Illness
2. Name: _____ (Last, First, M.I.) 3. SSN: _____
4. Occupation: _____ 5. Phone: _____
6. Date of Birth: _____ 7. Sex: ☐ Male ☐ Female
8. Date/Time of Accident/Illness: _____ Time: _____ ☐ AM ☐ PM
9. Duty Station Address:
10. Location of Incident:
11. Description of Incident:
12. Extent of Injury or Illness and Body Parts Affected:

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

13. Medical Treatment? ☐ Yes ☐ No 14. Lost Time? ☐ Yes ☐ No
15. Investigator's Name: _____ 15. Investigation Date: _____
16. Findings:
17. Amount of Property Damage: $ _____
18. Corrective Action:
19. Completion Date: _____ ☐ Estimated ☐ Actual

Investigator's Signature: _____ Date: _____
Title: _____ Phone: _____

Distribution: Original; Employee Supervisor; Employee; Safety Representative.
ADMINISTRATION/IPSG ELECTRONIC FORM

NOAA DIVING PROGRAM - DIVING INCIDENT REPORT FORM

NOTE: This form shall be used by NOAA Unit Diving Supervisors to report serious diving related injuries including near-drowning, decompression sickness, gas embolism, lung overexpansion, or injuries that require hospitalization. An additional narrative and detailed analysis of the incident MUST be attached. Contact the NOAA Diving Center with questions about whether or not to report an incident.

I. GENERAL INFORMATION ON ACCIDENT VICTIM

DIVER NAME:	DATE & TIME OF INCIDENT:
DIVE UNIT & LOCATION:	NOAA DIVING CERTIFICATION LEVEL:
CURRENT MEDICATIONS:	CURRENT HEALTH PROBLEMS:

NOAA Observer divers and non-NOAA divers complete this section. All other NOAA divers skip to the next section.:

AGE:	SEX: (M/F)	HIGHEST DIVE CERTIFICATION LEVEL:	CERTIFYING AGENCY:
# YEARS DIVING:	TOTAL # DIVES:	# DIVES LAST 6 MONTHS:	PREVIOUS DIVE INCIDENTS & DATE:

II. EQUIPMENT USED BY ACCIDENT VICTIM

BREATHING LOOP:	DIVER DRESS:	DIVE CYLINDER TYPE AND SIZE:	CYLINDER PRESSURE IN:	SEP ISSUED EQUIPMENT?
☐ Open-Circuit ☐ Semi-Closed / Closed Circuit ☐ Surface Supplied ☐ Snorkel	☐ None/Dive Skin ☐ Wet Suit thickness_____ ☐ Dry Suit	BREATHING GAS:	CYLINDER PRESSURE OUT:	☐ YES ☐ NO DIVER FAMILIAR WITH EQUIPMENT?

III. DIVE INFORMATION - Incident Dive

NAME - ON-SITE DIVING SUPERVISOR/LEAD DIVER:	AIR TEMP (°F):	WATER TEMP (°F):	U/W VIS (FT):	CURRENT SPEED (KTS):

NAME - DIVE BUDDY:	DIVE PURPOSE & LOCATION:
DIVE BUDDY AFFILIATION: ☐ NOAA ☐ OTHER _____	DIVE PLATFORM: / SURFACE CONDITIONS:

# DIVES, DAY OF INCIDENT:	# DIVES, PREVIOUS DAY:	TYPE OF DIVE:	DIVE(S) CONDUCTED WITH:
		☐ Duty ☐ Non-Duty	☐ Dive Tables ☐ Dive Computer (Model _____)

☐ YES ☐ NO **Was this dive typical of diver's normal type of diving? If NO, explain:**

List any problems encountered during incident dive or previous dives:

IV. DIVE PROFILE(S) - Day of Incident

DIVE #	START TIME	MAX DEPTH (FT)	BOTTOM TIME (MINS)	END TIME	SURFACE INTERVAL (HR:MIN)	DECO STOP? (Y/N)	SAFETY STOP? (Y/N)	STOP PROFILE (DEPTH / TIME)	COLD OR ARDUOUS? (Y/N)	FAST ASCENT? (Y/N)	INCIDENT DIVE? (Y/N)
1.											
2.											
3.											
4.											
5.											
6.											

NOTE: Additional dive profiles for the day of the diving incident can be attached to this form.

V. EMERGENCY PROCEDURES

YES	NO		YES	NO	
☐	☐	Emergency oxygen available on-site?	☐	☐	Dive accident management plan in place for dive site?
☐	☐	Emergency scenarios (low on air, out of air, lost buddy, etc.) discussed with all divers prior to diving operations?	☐	☐	Dive accident management plan reviewed by all divers and support persons prior to diving operations?

VI. SIGNS/SYMPTOMS & ON-SITE MEDICAL TREATMENT

DATE OF INJURY ONSET:

TIME OF INJURY ONSET:

SIGNS, SYMPTOMS, AND LOCATION ON BODY:

PRE-DIVE HEALTH, DESCRIBE:

FATIGUE/LACK OF SLEEP PRIOR TO DIVE?: ☐ YES ☐ NO

ALCOHOL CONSUMPTION, PREVIOUS 24 HRS:

STRENUOUS EXERCISE 6 HRS PRE OR 12 HRS POST DIVE?: ☐ YES ☐ NO

INJURIES SUSPECTED:
- ☐ AGE
- ☐ DCS
- ☐ Other Barotrauma
- ☐ None
- ☐ Other _____ _____

ON-SITE FIRST AID TREATMENT:

ON-SITE OXYGEN ADMINISTRATION:

Delivery Method _____ Time Started _____ Time Stopped _____

INITIAL EMERGENCY CONTACT (NAME OF PERSON OR AGENCY):

TIME CONTACTED:

EMERGENCY TRANSPORT METHOD(S):

FIRST AID DURING TRANSPORT:

TIME TRANSPORT STARTED

VII. MEDICAL INFORMATION - Hospital (Attach ALL ER, Hyperbaric Unit, and follow-up medical records)

HOSPITAL NAME AND LOCATION:

HOSPITAL TREATMENT:

ARRIVAL DATE AT ER:

ARRIVAL TIME AT ER:

HYPERBARIC UNIT NAME AND LOCATION:

CHAMBER TYPE:
- ☐ Monoplace
- ☐ Multiplace

CHAMBER TREATMENT:
- #1 Time Started _____ Time Stopped _____
- #2 Time Started _____ Time Stopped _____
- #3 Time Started _____ Time Stopped _____

TREATMENT TABLE / DESCRIPTION:

TABLE EXTENSIONS:

RETREATMENT TABLE / DESCRIPTION:

DESCRIBE WHEN RELIEF FROM SYMPTOMS OCCURRED:

DESCRIBE ANY RESIDUAL SYMPTOMS AFTER TREATMENT:

DURATION OF RESIDUAL SYMPTOMS: _____ Days

FINAL DIAGNOSIS:
- ☐ DCS I ☐ AGE ☐ Other:_____
- ☐ DCS II ☐ Pulm. Barotrauma _____

NOTE: A Diving Incident Report shall be completed by the **Unit Diving Supervisor** and be submitted to their Line Office Diving Officer within 10 days of the diving incident. This report shall consist of the following items:

1. **Diving Incident Report Form**
2. A **cover memorandum** providing a narrative of the diving incident, including a causal analysis and recommendations for prevention of future injuries.
3. **Medical records** associated with any medical treatment of injuries resulting from this incident.

The **Line Office Diving Officer** shall submit the UDS report, along with their own causal analysis and recommendations for prevention of future injuries to the Director, NOAA Diving Program **within 30 days of the incident**.

PRINTED NAME - UDS

SIGNATURE - UDS

DATE

NOAA DIVING PROGRAM
POST-DCS QUESTIONNAIRE

Note: The purpose of this questionnaire is to gather additional information concerning your recent decompression sickness incident. It is our hope that these data will help us better understand the "subjective" aspects of the incident. Thank you in advance for completing this form.

Name: _____ Date: _____

Date of DCS Event: _____ Date(s) of Treatment: _____

1. What was your level of fatigue at the start of the dive class?
   - ____ None
   - ____ Slight
   - ____ Moderate
   - ____ Severe

2. What was your level of fatigue <u>on the day before</u> you first experienced symptoms of DCS?
   - ____ None
   - ____ Slight
   - ____ Moderate
   - ____ Severe

3. What was your level of fatigue <u>on the day</u> you first experienced symptoms of DCS?
   - ____ None
   - ____ Slight
   - ____ Moderate
   - ____ Severe

4. Did you find the diving class to be a physically strenuous activity?
   - ____ yes
   - ____ no

5. Did you find the diving class to be mentally/emotionally stressful?
   - ____ yes
   - ____ no

6. What time did you go to bed <u>the night before</u> you first experienced symptoms of DCS? ____ pm. Was this normal?
   - ____ Yes
   - ____ No

7. What time did you wake up on the morning you first experienced symptoms of DCS? ____ pm. Was this normal?
   - ____ Yes
   - ____ No

8. On an average, how many hours sleep did get each night during the class? ____ hrs. Was this normal?
   - ____ Yes
   - ____ No

9. Did you sleep well?
   - ____ Yes
   - ____ No

10. How many hours sleep did get the night before you first experienced symptoms of DCS? ____ hrs. Was this normal?
    - ____ Yes
    - ____ No

11. Did you consume any alcoholic drinks within 72 hours of first symptoms of DCS?
    - ____ yes
    - ____ no

12. If you answered yes to the above question, how many drinks did you have and when?
    _____

13. Did you take any prescription or over-the-counter medications during the class?
    - ____ yes
    - ____ no

14. If you answered yes to the above question, please list what medications were taken and when?
    _____

15. Did you take any vitamins or herbal medications?
    - ____ yes
    - ____ no

16. If you answered yes to the above question, please list what medications were taken and when?
    _____

17. Did you use any street drugs (i.e., marijuana, cocaine, pills, etc.) during the class?
    - ____ yes
    - ____ no

18. If you answered yes to the above question, please list what drugs were taken and the quantity?
    _____

19. Did you use any street drugs within 30-days of the start of the training class?
    - ____ yes
    - ____ no

20. If you answered yes to the above question, please list what drugs were taken and the quantity?
    _____

21. Did you do any vigorous exercise (i.e., running, hiking, brisk walking, weight lifting, bicycling, aerobics, dancing, etc.) during the training course on a daily basis either before or after dive class?
    - ____ yes
    - ____ no

22. If you answered yes to the above question, please list what type of activities?
    _____

23. What activities were you doing prior to the onset of your symptoms? _____
    _____
    _____

24. Are these activities normal for you?
    - ____ Yes
    - ____ No

25. Was there anything that stands out that was either very physically or emotionally stressful 72 hours prior to the incident?
    - ____ yes
    - ____ no

26. If you answered yes to the above question, please explain?
    _____
    _____

27. Was there anything that stands out that was either very physically or emotionally stressful 48 hours prior to the incident?
    - ____ yes
    - ____ no

28. If you answered yes to the above question, please explain?

_____

_____

29. Was there anything that stands out that was either very physically or emotionally stressful within 24 hours prior to the incident?
    - ____ yes
    - ____ no

30. If you answered yes to the above question, please explain?

_____

_____

31. Was there anything that stands out in your mind that made you feel ‘unusual’ within 2 hours prior to the dive?
    - ____ yes
    - ____ no

32. If you answered yes to the above question, please explain?

_____

_____

33. Is there anything that stands out that was either very physically or emotionally stressful between the time you surfaced and the onset of symptoms?
    - ____ yes
    - ____ no

34. If you answered yes to the above question, please explain?

_____

_____

35. While suiting up, did you experience any equipment problems that made you concerned?
    - ____ yes
    - ____ no

36. If so, did you feel like you were thinking about that issue a lot during the dive?
    - ____ yes
    - ____ no

37. If you answered yes to the above question, please explain?

_____

_____

38. Did you feel that the dive itself was particularly physically demanding?
    - ____ yes
    - ____ no

39. From the time you surfaced to the onset of symptoms, did you think about DCI a lot?
    - ____ yes
    - ____ no

40. What activities, other than resting, eating, and sleeping, did you do during the training course on a daily basis either before or after dive class?

    _____
    _____

41. Do you feel that you maintained an adequate hydration level during the training class?
    - ____ yes
    - ____ no

42. Do you feel any one dive contributed to your DCS symptoms?
    - ____ yes
    - ____ no

43. If you answered yes to the above question, please indicate the dive profile?

    _____
    _____

44. **Females only:** Did you have menstrual flow on the day you first experienced symptoms of DCS?
    - ____ yes
    - ____ no

45. **Females only:** If yes, when (date) did the menstrual flow start and finish?
    - ___/___/___ Start
    - ___/___/___ End

46. **Females only:** Was the timing and flow typical of your normal period?
    - ____ Yes
    - ____ No

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

Signature: _____ Date: _____